

# Dignity and death: a reply

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## Author's abstract

*Some form of utilitarian approach can be discerned as underlying much current medical ethical decision-making. Criticisms of the practical effects of such an approach are not parried by asserting the fundamental strengths of utilitarianism as theory.*

'The true meaning of a term is to be found by observing what a man *does* with it, not by what he *says* about it' (1).

In offering a reply to the responses to my earlier paper (2) by the editorial writer of that edition of the journal (3), by Robertson (4) and by Harris (5), I do not wish to confine myself solely to defending my previous piece. Nevertheless, the variety and intensity of the objections seem to demand some defence, which I hope to link into an attempt to advance my argument.

The un-named editorial writer accuses me of launching 'a scathing attack on utilitarianism' and 'a miscellany of other targets' including Robertson's living will proposal. This criticism would have been more valid if the writer had confined himself to criticising only what I actually wrote. In the two of his paragraphs (seven sentences) which deal directly with my paper the following are the more important errors.

A) I am said to have attacked the living will concept. I did not.

B) I am said to have attacked a 'miscellany of other targets' aside from those specified. I cannot detect any other targets which I attacked and must assume this phrase is being used figuratively; for what purpose is not clear.

C) I am said to have had as my main target 'the adequacy of utilitarianism as a moral theory'. This is grossly misleading.

It should be plain from my paper (it is actually stated there) that I do not object in principle to the living will concept, though I am not satisfied (and this I did not state nor even imply) that Robertson's apparent assumptions about the effects, financial and otherwise, of encouraging its adoption, are correct. I am well aware that various ethical approaches to the brain-

damaged elderly are consistent with the living will idea. I said (2), 'There is no compelling logic connecting acceptance of the "living will" concept and its use to facilitate euthanasia of the brain-damaged elderly'. Now this is hardly an assertion that the living will is a wonderful idea. How an attitude thus expressed, however, could be labelled an attack on the living will concept, escapes me entirely. I have to plead that this part of the editorial writer's accusation is unsupported by any evidence and I am puzzled as to why it was laid.

The chief criticism of the editorial, however, is that I have set up 'utilitarian straw men' to attack, and it is said that I should criticise utilitarian theories at their strongest. This is a rather odd remark. Am I not allowed to attack a theory at its weakest point? The editorial appears to be advocating an intellectual version of trench warfare – frontal assaults on well-defended positions. I should think that this would be as little likely to gain ground in the intellectual sphere as it proved itself to be in the military. It is notable that the editorial writer, whilst advocating such a policy for me, wisely eschews it himself. He deals not with the effects of utilitarian ideas *in practice* but concentrates instead on the strength of utilitarianism as theory, an area in which, as he has accurately perceived, I have little claim to expertise. I, however, as is surely clear from my paper, am much more interested in the effects of applying utilitarian ideas, or some forms thereof, in the day-to-day world of ethical decision-making; and particularly in medicine. I do not see how my critique is dented by asserting the *theoretical* strengths of utilitarianism.

Neither the editorial writer nor Harris (5) claim that the ethical attitudes I have ascribed to Robertson and others are not utilitarian in any form. It may be that they could do so and defend such a claim, though others (6), (7), (8) and many more, have made statements about the utilitarian nature of much medical ethical thinking. I am unaware of any attempts to correct such statements in this journal before.

Harris (5) may be right to claim that my conclusions say nothing about the value of a broadly utilitarian approach to medical ethics. But, notwithstanding the editorial statement to the contrary, I was not attempting to criticise such an approach. Instead I wish

## Key words

Utilitarianism; medical ethics; moral theory; living will.

to exemplify the effects of a utilitarian approach in practice; the approach I seem to see and hear about in real life. If such an approach is the one that doctors actually use, its lack of subtlety may be the only problem. It *may* be the case that a subtle, sophisticated utilitarian approach can deal with medical ethical issues more satisfactorily. It may be proposed that utilitarianism, as a term, should be reserved for such sophisticated version of the theory and cannot be found reflected in real life. Such a position would seem to parallel the assertion that Communism as a theory or doctrine should not be judged by the failings of its aberrant offspring in the real world. As a statement this may be literally true. As a prelude to advocating the adoption of the theory it has some obvious shortcomings. My intention being to illumine 'the practical effects of the utilitarian ethic' as I said (2), I do not see why I should be instructed to attack utilitarianism in its most theoretically developed form.

To be plain then, I am not naively assuming that the criticisms I am offering of the kind of utilitarian ethic I see in use in medicine can be applied in full force to a sophisticated utilitarian theory. On the other hand, I do not accept that they are utterly irrelevant, either. I will return to this point later.

Again, it may be true, as the editorial has it (3), that utilitarians have been foremost in attacking the acts/omissions doctrine. However, the example I described (2) of this doctrine being invoked does have relevance to a debate on practical utilitarian ethics. The dichotomy between acts and omissions was invoked in the trial of Dr Leonard Arthur to support a defence based on what appears to me to be a utilitarian approach to medical ethical questions (9). The medical experts testifying at that trial appear to have thought that invoking the dichotomy would enable decisions to seek death in certain handicapped children, decisions made from an apparently utilitarian standpoint, to be implemented with less emotional trauma. The dichotomy is similarly invoked by Lorber (10) to support similar decisions arrived at from an apparently similar empirical ethical standpoint.

If it is true that utilitarians have attacked the acts-omissions doctrine, and if it is also true, as seems to me, that people invoke this doctrine whilst approaching ethical decisions from a utilitarian point of view, then it is clear that some confusion exists. It is not clear that I am its victim.

In his response to my paper (5) Harris makes a number of statements criticising the practice of replacing moral argument with misleading labels and slogans, an offence of which he says I am guilty. As an example of the 'misunderstandings and confusions' which my arguments are said to display he quotes my supposed rejection of attempts to widen the scope of the moral debate about topics such as euthanasia. He feels my dislike for such a widening derives merely from the association of this widening with utilitarianism. The attaching of misleading labels and slogans is said to have led to this, my judgement being

clouded by my wish to reject utilitarianism.

This criticism would be quite damning were it not for the fact that I did not actually express any preference *at all* in the matter of widening the scope of the ethical debate. The argument I was advancing was that, in order to be consistent, utilitarians would seem to be required to be in favour of widening the scope of the debate, as indeed Robertson is (11). Some people, however, who appear to support a utilitarian position (12) are not so in favour, rejecting the intervention of 'certain moralist groups' which are presumably felt to have no right to express an opinion. This appears to betray an inconsistency.

Personally, I am in favour of widening the scope of the moral debate, a view I seem to share with Harris. I can only explain the origin of Harris's criticism of me by turning it on its head. He has identified me as rejecting utilitarianism, he has seen that I identify utilitarianism with a wish to widen the scope of the moral debate and therefrom he has deduced, incorrectly, that I will wish to reject such a widening. Hence the 'misunderstandings and confusions' to which he refers.

It seems to me that the fundamental difference between myself and Harris turns on the separation of theory and practice. Harris is rejecting what to him seems a crude attack on utilitarianism as moral theory, whilst I intended my attack to be upon the version of it which I seem to see in moral practice. Perhaps this difference was not sufficiently underlined in my original paper.

As an example of the difference, I would like to look at Harris's idea that people in general would be rendered very unhappy by the notion of an elderly person killed in part to appease the distress or ameliorate the finances of his or her relatives. Harris maintains that the general unhappiness of 'most people' in society who heard of this idea would easily counterbalance the happiness the relatives would have acquired. This is fine in theory, a theory which Harris rightly says is limited in scope by the bounds I set upon it. The problem, though, is that such things *do* happen. In practice the methods which Robertson propounds (11) *are* used in order to 'accurately mimic natural dying'. And most people are not rendered in the least unhappy by this – because they do not know anything about it.

It may be argued that the relatives and staff acting as described to end the life of a patient are not acting in accordance with any form of utilitarianism. Yet it is probably quite possible to show that the 'sum total' of human happiness *was* increased by their actions precisely because 'most people' who might be shocked, are in fact in ignorance, and the general tenor of their collective mood remains undisturbed. No one advertises specific examples of this kind of behaviour. On the contrary, it is disguised by phrases such as 'mimicking natural dying' (11) used apparently to avoid the induction of what Lorber calls 'guilt complexes' (10) which might interfere with the whole

process.

It is just this sort of practical consideration that seems to separate utilitarian theory from ethical practice in the field of medicine. Harris goes on to suggest that some form of rule-utilitarianism would seem to completely overcome the difficulties I have raised. He says (5), '[it is] often argued, that adherence to the principles of conventional morality itself makes such a contribution to human happiness, that it would be difficult for classical utilitarians to justify major revisions of this system in the name of utility'. Yet precisely this is being done and in the name of utility. One such principle that Harris mentions, respect for life, is already circumscribed and really quite relative in the advocacy of those who support the assessment of utility as their guiding moral principle. Whatever the ethical merits or otherwise of their concerns for their patients' 'quality of life', the respect for life *itself* shown by Robertson (11) or Lorber (10) is not easily viewed as falling within the ambit of 'conventional morality'. It has, depending on your point of view, evolved or degenerated, and specifically in the name of utility.

I do not believe that such practical problems are resolved by demonstrating that the theory can deal with them perfectly adequately.

It is difficult to know how to respond to Dr Robertson's personal attack upon me (4). He refers to my paper as intemperate, self-righteous etc. The justification, or lack of it, for this kind of description I leave to the reader. However, I do not believe one should ignore his recommendation that my paper should not be taken seriously nor the remarks implying that he will treat the subject on a level superior to that which I adopted. This is the attitude which I had in mind when I wrote (2) of people failing 'to respect the integrity of other moral approaches'.

Robertson claims I have mischievously bent his ideas and summarised his thoughts incorrectly (4). He does not trouble, however, to say in which direction I have bent his ideas and I shall not deal any further with this accusation, believing there to be no substance to it. Robertson agrees that the approach he advocates will 'incorporate certain features of utilitarianism' though he says that his motives for adopting his approach were not utilitarian. Whatever his motives, which I shall not question, it does indeed appear that his system of ethical thought is, to some large extent, dependent on the assessment of utility, and it was this aspect that interested me. As I stated from the outset (2) I have no interest in attacking the principle of the living will, which I think is of most interest to Robertson. I am, however, interested in the way that Robertson's utilitarian approach appears to foster euthanasia. The linking of the living will idea to this approach is almost coincidental in my opinion.

The living will has some attractive features but could hardly be advocated as a major advance in medical practice by anyone familiar with geriatrics or psychogeriatrics. I have worked in this field for a number of years and in various health districts and I do

not recall having met a single geriatrician or psychogeriatrician who does not listen to his patients though no doubt some exist. Nor have I met a practitioner in this field who tries to treat his patients out of the context of friends and family, as Robertson assumes I am advocating (4). A socio-psycho-biological approach to health care in the elderly has been accepted as good practice for many years now and any attempt to advocate its adoption smacks of re-inventing the wheel. This is not an issue between us.

Within the family context certain features of the care of the demented stand out. Though relatives do agonise over a patient's loss of dignity and autonomy, they agonise far more over the chronic lack of resources within the health service to help them cope in the real, practical world of soiled sheets, broken sleep and absent social life. It is my opinion, which I shall not defend here, that resources have already been shifted too far away from this group of patients and their needs. One of my major concerns about Robertson's overall position is that the strong concentration on a very limited aspect of patient 'dignity' may serve to distract society from the need to do something really useful, such as providing adequate services.

It may be argued that more living wills should lead to fewer such chronic problems and therefore to more money for the remainder. Not only is it quite unjustifiable to assume that Robertson's policy would make any serious impact on such a numerically enormous problem in financial terms, but also, even if it did, let us remember that Robertson believes the public would rather have the money spent on younger, curable patients.

I am not aware that public opinion has actually been canvassed on this issue, but I am assuming here that Robertson himself advocates such a shift of resources between patient groups. I have considerable difficulty comprehending the juxtaposition in one proposal of two such seemingly contradictory attitudes: the living will concept and its attendant emphasis on dignity and respect for the elderly patient on the one hand; and on the other, reallocation of much-needed resources away from the same patient group. The former I consider laudable, though hardly a great advance in medical practice. The latter, linked as it is to proposals aimed at facilitating euthanasia from a utilitarian standpoint, I see as far more important and it is therefore, the focus of my attention.

## References

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## Editor's note

I have carefully reviewed Dr Brooks's original paper and my editorial criticising it. I am unpersuaded that my criticisms are erroneous. Interested readers are invited to scrutinize the competing arguments and make up their own minds. Drs Robertson and Harris were invited to respond but, for reasons similar to mine, declined.

Raanan Gillon